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ABSTRACT

This study surveyed 300 Illinois special education teachers concerning their views on effective practices for intervention with students having attention deficit disorder (ADD) and their suggestions for regular classroom teachers with such students. Introductory material defines the problem and terminology and identifies assumptions and limitations of the study. A review of the literature examines what ADD is, the causes of ADD, diagnosis of ADD, consequences of ADD behavior, and interventions with ADD children (medication, treatment alternatives, and classroom intervention). Among study findings based on a 61% response rate (N=183) were: 68 percent favored seating the ADD student near the teacher; 66 percent favored a special education setting for ADD students; over 70 percent recommended that a student's work be divided into small pieces; 90 percent preferred to provide nonverbal feedback; and 88 percent taught their students self-monitoring techniques. Tables detail the survey findings, and 10 appendices include letters, the questionnaire, teacher comments, general suggestions for regular education teachers, and general comments regarding ADD. (Contains 54 references.) (DB)

PRACTICES
OF SPECIAL EDUCATION TEACHERS
FOR DEALING WITH STUDENTS
WITH ADD/ADHD

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A MASTER'S THESIS SUBMITTED TO THE GRADUATE
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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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This thesis was approved by

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Advisor

_____

Acting Dean, School of Education

DEDICATION

To my son, Ron, a young man with ADHD,
whose condition led me to pursue
research in the area of ADD/ADHD
in the hope that all children with this disability
and their families will be understood.

To my daughter, Jennifer, may she one day
understand why Ron was a "world-class pain."

To Don for his encouragement,
support and friendship.

I'm glad for who you are!

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To Meg Carroll and Dorothy Binder

for their professional assistance.

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CHAPTER 1

INTRODUCTION TO THE PROBLEM

Introduction

Many children share a set of symptoms which include short attention span, trouble concentrating, distractibility, and, occasionally, hyperactivity. A condition which was previously labeled as hyperactivity, hyperkinesis, minimal brain damage, minimal brain dysfunction, Werner-Strauss Syndrome, learning disability, impulse disorder, postencephalitic hyperactivity, today is known as Attention Deficit Disorder (ADD) (Phelan, 1989). In 1980, the American Psychiatric Association changed the designation of hyperactivity to Attention Deficit Disorder with Hyperactivity (ADD-H) in the Diagnostic and Statistical Manual (DSM III). In 1987, in the DSM III-R the term Attention Deficit Hyperactivity Disorder (ADHD) was coined (Garber, Garber, & Spizman, 1990).

The problems of ADD may affect 5% of the school-age population, mainly boys. The problems of ADHD may affect 3% of the school age population, i.e., one child with this problem may be observed in every classroom of the United States (Greenberg & Horn, 1991). Hunsucker (1988) asserted that if every person with ADD were treated early there would be a reduction in the juvenile,

as well as adult, crime rate, reduction in the school drop-out rate, and a reduction in alcohol and other drug abuse.

Some educators do not have complete knowledge of ADD and/or ADHD. Educators know that their students are on medication but do not know the severity of the disorder. Others realize that a child has obtained high scores when referred for services, and then think that the child does not need extra help.

Teachers are the individuals who are spending many hours of each day with ADD and/or ADHD children. It is in school where many difficulties become apparent, and it is usually not until a teacher complains that a doctor will prescribe medication for an ADD and/or ADHD child. At the present time, ADD is not a separate category in the Individuals with Disabilities Education Act (IDEA) although the child may be eligible for services under other health impaired or seriously emotionally disturbed categories. On September 16, 1991 the United States Department of Education issued a memorandum entitled "Clarification of Policy to Address the Needs of Children with Attention Deficit Disorders within General and/or Special Education." The national goal is that these children reach their fullest potential. The Federal Resource Center is in the process of working with state educational agencies (SEAs) and six regional resource centers to identify intervention strategies being implemented across the

country for children with ADD (Davila, Williams, MacDonald, personal communication, September 16, 1991).

Burcham (personal communication, June 24, 1992) of the Federal Resource Center at the University of Kentucky, Lexington, Kentucky, stated that the Center is currently researching issues related to "successful practices" in classrooms. The timeline for the project is mid-1993. Becker (personal communication, June 23, 1992) of Research Triangle Institute of North Carolina indicated that the Institute is also studying issues related to "successful practices" and has no information about them available at the present time.

Purpose of the Study

The purpose of this study was to contact selected special education teachers in the State of Illinois to ask them for input on what they consider effective practices for intervention with ADD students. It was the purpose of this proposed research to find out what teachers in the special education field consider the best ways to handle students with Attention Deficit Disorders.

Research Questions

The research questions posed for this study were:

1. In dealing with students with ADD and/or ADHD, what do special education teachers find are the most effective practices for intervention in the classroom?

2. What advice can special education teachers give regular education teachers who may have one or more ADD and/or ADHD students in their classrooms?

Definition of Terms

The definitions of terms important to this study are as follows:

Antecedent Conditions: Setting and environmental design issues such as type of class (e.g., regular vs. special class, "open" vs. "traditional" classroom), the structure of the setting (e.g. the daily schedule, class rules), seating arrangements, and characteristics of the task (Abramowitz & O'Leary, 1991).

Attention Deficit Hyperactivity Disorder (ADHD):

A. A disturbance of at least six months, during which at least *eight* of the following behaviors are present:

1. often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)

2. has difficulty remaining seated when required to do so

3. is easily distracted by extraneous stimuli

4. has difficulty awaiting turn in games or group situations

5. often blurts out answers to questions before they have been completed

6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension); e.g., fails to finish chores

7. has difficulty sustaining attention in tasks or play activities

8. often shifts from one uncompleted activity to another

9. has difficulty playing quietly

10. often talks excessively

11. often interrupts or intrudes on others; for e.g., butts into other children's games

12. often doesn't seem to listen to what is being said to him or her

13. often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)

14. often engages in physically dangerous activities without considering possible consequences

(not for the purpose of thrill seeking); e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM III-R criteria for disruptive behavior disorders

B. Onset before the age of seven

C. Does not meet the criteria for a pervasive developmental disorder (Lerner & Lerner, 1991, p. 8)

Attention Deficit Disorder (ADD): The same as Attention Deficit Disorder with Hyperactivity except that the individual never has had signs of hyperactivity (Cantwell, 1986).

Cognitive Behavior Modification: "A method that attempts to impart self-instructional, self-monitoring, and self-reinforcing skills to the child" (Kinsbourne & Caplan, 1979, p. 258).

Contingency Management: The application of consequences contingent on specified child behaviors (Abramowitz & O'Leary, 1991).

Intervention: Strategies that can be used to help the ADD and/or ADHD children during their time in the classroom.

Medication: Prescribed substance, commonly a central nervous system stimulant, "used to improve the child's ability to

concentrate, stay on task and lessen impulsivity and distractibility" (Coleman, 1988, p. 26).

Reductive Procedures: Use of reinforcers to reduce rates of inappropriate behavior. Various schedules, timings, and rates of providing reinforcement are employed (Lerner & Lerner, 1991).

Stimulant Medication: Primarily methylphenidate (Ritalin) and tricyclic antidepressants such as imipramine and desipramine (Gomez & Cole, 1991).

Token Economies: Awarding or removal of tokens or points contingent upon specific desirable or undesirable behaviors. (Lerner & Lerner, 1991).

Assumptions

The assumptions made in conducting this research were:

1. Teachers who responded have had experience with a student(s) with ADD and/or ADHD.

2. Teachers who participated in this study responded carefully and honestly.

3. All administrators and staff members in the schools in which the teachers work are committed to the success of all their students.

4. The questionnaire contains items of concern to teachers.

5. The responses may provide ideas and insights to be shared with regular education teachers who have students with ADD and/or ADHD in their classrooms.

6. Based on some research reports (Hunsucker, 1988; Moffitt, 1990; Tremblay, et al., 1992), it can be assumed that poor school achievers are at a higher risk for delinquent acts.

7. Success in the classroom will give children greater self-esteem which, in turn, will enhance their desire to stay in school and reduce the risk of delinquency.

Limitations and Scope of the Study

The limitations inherent to this study were:

1. A survey questionnaire was sent to a random selection of three hundred special education teachers in the State of Illinois, with the exception of the City of Chicago. There may be a low response rate.

2. Because the survey questionnaire had not been used previously and had been prepared by this researcher, it had no published validity or reliability.

CHAPTER II

REVIEW OF LITERATURE

There is a growing focus today on children who are easily distracted, have difficulty staying on task, impulsively engage in activities that may or may not be physically dangerous, and move around excessively. At the present time, experts cannot agree on what the problem is, the reasons for the problem, the consequences of the problem, or interventions. In this review of literature, a discussion of the following topics is included: attention deficit disorder, causes and diagnosis of attention deficit disorder, the consequences of attention deficit disorder, and the various interventions, i.e. medication, behavior programs, and classroom intervention.

What is Attention Deficit Disorder?

As early as the late 1800's medical scientists were concerned with children who were hyperactive and had difficulty attending. Their diagnoses implied that there was minimal brain damage. In 1902, such children were thought to have "morbid defects in moral control" (Lerner & Lerner, 1991). The concept of minimal brain damage extended into the 1940's. At this time, doctors realized that a number of children were having trouble with fine or gross motor skills, as well as difficulty imitating certain body

movements required in a routine neurological examination (Garber et al., 1990). The National Institute of Health, in 1966, recommended that the term "minimal brain damage" be replaced by "minimal brain dysfunction." Because there was not a set of diagnostic criteria to identify the disorder, in 1968, the American Psychiatric Association began to publish diagnostic criteria in Diagnostic and Statistical Manual of Mental Disorders (DSM II). In 1980, DSM-III established the term "attentional deficit disorder" and shifted the focus from activity to attentional problems (Lerner & Lerner, 1991).

The Diagnostic and Statistical Manual (DSM III-R, 1987) of the American Psychiatric Association contains a list of diagnostic criteria for Attention Deficit Disorder with Hyperactivity (ADHD). Fifteen behaviors are listed, and eight must be present in an individual for a positive diagnosis of this condition. The DSM III-R also includes a classification of Attention Deficit Disorder Without Hyperactivity (ADD). The criteria for this disorder are similar to that of ADHD "except that the individual never had signs of hyperactivity" (Cantwell, 1986, p. 7).

Since DSM III-R was published, there has been an elaboration on the characteristics by professionals in the field. Goodman and Poillion (1992), in reviewing literature related to identification and causes of ADD, found that 69 characteristics and 38 causes

were cited and that professionals are not in complete agreement. Goodman and Poillion (1992) state the following:

> In fact, no characteristic is cited by more than 80% of the authors, and only four of the 69 characteristics are listed by more than 50%. At the other extreme, there are 19 characteristics proposed by only one author. Of the 69 characteristics, 59 were put forth by less than 20% of the authors. (p. 41)

Phelan (1989) stated that problems of ADD may affect 5% of the school population. The boys outnumber girls, with a ratio of 6-7:1. Some researchers report that it is closer to 3-4:1. Phelan's research has also shown that ADD children will show different characteristics and behavior at different stages in their development from infancy to adulthood.

The ADHD problem may begin in utero. Accardo (1991-1992) gave the following scenario:

> . . . . In the womb this baby's gymnastics rarely allowed mom any rest during the pregnancy. The child is very colicky and irritable as an infant. The child learns to run right after he starts to walk, and then he gives up walking for running. (p. 17)

Greenberg and Horn (1991) remarked that 3% of the school population meet the DSM-III-R criteria for ADHD. This percentage equates to every classroom in the United States having a student with ADHD. This may seem to be a very small percentage, but according to Hunsucker (1988), less than 1% of the total population of children are classified as mentally retarded. There are special programs for the mentally retarded, but there are not special programs for children with ADD, despite their greater numbers.

What Causes Attention Deficit Disorder?

To date, there is no clearly known cause of ADD and/or ADHD. The growing consensus of the research is that it has a biological base and that environment may play a role.

Garber et al. (1990), Hunsucker (1988), and Phelan (1989) agreed that it is unlikely that the parents are the cause of the problem. Findings indicate that when family histories are examined, similar behavioral characteristics will be found among family members suggesting a genetic component. In 5-10% of the histories of children with ADD/ADHD there was a difficult birth.

It has been predicted that definitive answers may be forthcoming in the next few years because newer methods are now available to study the brain. Research related to a pattern of underactivity in certain parts of the brain is being conducted.

Studies regarding the effects of lead, nicotine, and/or alcohol passing from the mother to the fetus during pregnancy are also being conducted (Garber et al., 1990).

The effects of alcohol passing from the mother are evident in children with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE). These children's brains can be overloaded by a small amount of stimulus, and a conflict can cause a breakdown in their functioning. Many FAS and FAE children have attention deficit disorder (Wescott, 1991).

Feingold maintained that ADHD children suffer from an adverse reaction to various foods and food additives. However, controlled research studies have been unable to validate Feingold's findings (Garber, et al., 1990). Phelan (1989) and Hunsucker (1988), however, stated that some children may be diet sensitive, and the effect of this sensitivity on the child's behavior should be investigated. They both assert, however, that sugar is not a cause of ADD. Research conducted by Milich and Pelham (1986) failed to show a relationship between sugar ingestion and performance in the classroom or in a playground setting.

> Further, in light of the relatively high rate of physicians who are recommending sugar-restricted diets for their ADD clients (Bennett & Sherman, 1983), these results suggest caution in implementing such

interventions. Such a diet is both difficult to implement (see Wolraich, Stumbo, Milich, Chenard, & Schultz, 1986) and potentially stressful to the family. (Milich & Pelham, pp. 717-718)

The majority of the evidence suggests that ADD is an inherited, biochemical disorder. It is understood that neurotransmitters are involved in ADD, but there is uncertainty how the disturbance in those chemicals trigger attention deficits. Meade (1991) mentions that reduced glucose metabolism in certain parts of the brain of those diagnosed as having ADD has been observed, but the reason for the reduction is unclear.

Diagnosis of Attention Deficit Disorder

The guidelines for diagnosing ADD and/or ADHD are found in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., revised) (American Psychological Association, 1987). Other types of information are also collected through interviews and rating scales, as well as direct observation of the student (Atkins & Pelham, 1991; Guevremont, DuPaul, & Barkley, 1990; Roberts, 1986)

Phelan (1989) has suggested an 11-step diagnostic process: (a) matching Phelan's core symptoms (e.g., inattention, impulsivity, difficulty delaying gratification, hyperactivity,

emotional overarousal, noncompliance, social problems, and disorganization) against the parents' complaints; (b) matching a child's developmental history against Phelan's full-syndrome, untreated ADD history (i.e. the core symptoms); (c) taking a family history to determine if there is a possibility of other ADD members in the family; (d) completing Conners Questionnaires (Conners, 1986); (e) completing Situations Questionnaires (Achenbach, 1986; Conners, 1986); (f) gathering school information, i.e., grades, achievement test scores, teacher observations, psychological testing results; (g) evaluating previous diagnosis and treatment; (h) interviewing the child; (i) conducting physical and neurological exams; (j) giving psychological tests; and (k) asking parents to attend an ADD workshop. Guevremont, et al. (1988) maintained that parent interviews, teacher interviews, child interviews, child behavior ratings, parent rating scales, and teacher behavior ratings are important parts of the assessment process.

Several laboratory tests have also been developed to measure ADHD, which Guevremont et al. (1990) asserted have limited normative data. These are the Continuous Performance Test (CPT), which measures attention span or vigilance and the Matching Familiar Figures Tests (MFFT), which measures impulse control. Activity levels can be measured by an actometer or pedometer being

attached to a child's wrist or ankle to measure movement. Again, with these tests there is a limited amount of normative data (Guevremont et al., 1990).

Another diagnostic tool is the Gordon Diagnostic System (GDS), a microprocessor that administers a Vigilance Task that yields data regarding the ability to focus and maintain attention over time and in the absence of feedback. Older children and adults can be tested using a Distractibility Task. The unit can be used to also test for impulse control. Gordon contends that data garnered from these tests may help a practitioner evaluate the impulsive patient (Gordon, 1986). Grant, Ilai, Nussbaum, and Bigler (1990) stated, however, that only the Vigilance and Distractibility Tasks correlated consistently with other measures such as WRAT-R Arithmetic Sub-test, Beery Test of Visual and Motor Integration, and various sensory-motor variables from the Halstead-Reitan Neuropsychological Battery. They emphasized that the GDS is insufficient for the assessment of children having impulsivity and/or sustained attention problems.

Consequences of ADD Behavior

Many children are well behaved in a physician's office so their problem may remain undiagnosed and untreated. Accardo (1991-1992) pointed out that if a physician is not well-informed about ADD the child's condition may worsen. The child who is not

treated may be suspended from school because of conduct problems. Because such children cannot control their behavior, they will continue to get into trouble. As the frustration of all concerned mounts, the children will be at risk for very serious psychiatric and/or emotional problems.

Many ADHD children as they mature have problems with responsibility and as adults do not become gainfully employed, further contributing to a low self-esteem or low self-concept (Garber et al., 1990). They also have more problems with antisocial behavior. If these children do not receive therapy in childhood, researchers have demonstrated that they will have very aggressive tendencies. If, however, there has been an early intervention for ADHD children, chances are greater that they will be "indistinguishable from their peers" as adults (Garber et al., 1990, p. 218).

Walker, Lahey, Hynd, and Frame (1987) in a comparison study of specific patterns of antisocial behavior of those with conduct disorder with hyperactivity to those with conduct disorder without hyperactivity found the following:

> . . . . that when ADD/H is present, the onset of CD [Conduct Disorder] is earlier or the developmental progression from less serious to more serious antisocial behaviors is more rapid. In addition,

aggression, the total number of antisocial behaviors during childhood, and age of onset are also predictive of poor antisocial outcome after puberty (Loeber, 1985), which further suggests that the co-occurrence of CD and ADD/H is associated with a pattern of antisocial behavior that is more persistent. (p. 912)

Kramer (1986) also describes males with ADD, who, as children, displayed aggression and as adults were having difficulties with the law. He concluded that if children display more aggression when they are young that they will engage in more antisocial behavior as adolescents and as adults.

Moffitt (1990) conducted a longitudinal analysis of the behavior of a birth cohort of 435 boys in New Zealand and found that boys with the co-morbidity of ADD and delinquency showed antisocial behavior that began early in childhood. She had three subgroups. The "ADD nondelinquents" (p. 905) evidenced no deficits in verbal IQ or motor abilities but showed mild reading problems. Their antisocial behavior was mild and transient. The "Non-ADD delinquents" (p. 905) exhibited delinquent behavior at age 13, after a childhood free of antisocial behavior. They had "no significant deficit in verbal IQ, no difficulty with reading, no notable family adversity before age 11, and no perinatal or motor skills problems." (p. 905). The "ADD + delinquents" (p.

905) prior to age five had significant deficits in motor skills and family adversity. IQ deficits surfaced by age five and remained stable. They also were failing reading upon entering school, and these students experienced difficulty processing social information in interpersonal interactions. Her study further illustrated that childhood antisocial behavior appears to be responsive to environmental influences and that it is desirable that the intervention be early in a child's development. Moffitt mentioned that at least three other longitudinal studies indicated that subjects with ADD and aggression continued their illegal or unacceptable behavior into young adulthood.

There is a possibility that there is a relationship between ADD/ADHD and Developmental Reading Disorder (DRD). Richardson, Kupietz, and Maitinsky (1986) demonstrated that these students could be taught to read, but success was dependent upon the children being on a medication program.

Tremblay et al. (1992) maintained that poor school achievers are at a high risk for becoming involved in deviant behaviors and that their disruptive behaviors begin in first grade. Sakheim, Osborn, and Abrams (1991) concluded that those individuals with high levels of aggression and antisocial behavior were at a high risk of becoming fire-setters.

A study of preschoolers by Szumowski, Ewing, and Campbell (1986) indicated that when characteristics of ADD are present it is likely that the behavioral patterns will continue throughout the school years. They asserted, however, that at this early age the prediction is not straightforward. They stressed that it is important to observe the children in a variety of settings, to consider parental perceptions and behaviors, and view the family in a social context.

Hunsucker (1988) first assumed that he would be able to "cure" children with behavioral problems through the use of behavioral modification techniques. He soon learned that what he suggested to parents, they had already tried without success. It was at this point that he learned that many of his colleagues were unaware of Attention Deficit Disorder and that many children with ADD were being referred to psychologists because of the presence of other problems. He stated that if every person with ADD were treated at an early age that there would be reductions in the adult and juvenile crime rate, school drop-out rate, and alcohol and other drug abuse. Because of impulsiveness, ADD adolescents may be responsible for unwanted pregnancies, and their low self-esteem may account for a high incidence of suicide and depression. Not considering the consequences of their actions, may also be the

cause of a high incidence of car accidents because the child is more reckless and is looking for excitement.

In the past ten years there has been an increase in both the number of school children labeled learning disabled and drug abusers (Fox & Forbing, 1991). Some of the symptoms of ADD are not only descriptive of learning disabled students but also children who are using alcohol and illegal drugs. Fox and Forbing (1991) emphasized that it is necessary that students be referred for intervention and treatment of the substance abuse problem before intervention of the educational problem. ADD students are also at high risk for substance abuse, because they

> . . . . have been found to be deficient in norepinephrine, a neurotransmitter blocker, resulting in flooding of the neurotransmitter to the motor cortex, which in turn elicits hyperactivity (Tennant, 1987). Tennant warns that hyperactive children should not be allowed to use drugs other than those prescribed. Even tobacco use affects the production of norepinephrine, and it also increases the risk for later chemical abuse (O'Connor, Hesselbrock, & Tasman, 1986; Tennant, 1985a). Interestingly, Goodwin (1974, 1979) found that 50% of male alcoholics exhibited

symptoms of hyperactivity in childhood. (Fox & Forbing, 1991, p. 26)

Because most students with ADD/ADHD have low self-esteem, low achievement, impulsivity, lack of problem-solving skills, and are not readily accepted by their nonhandicapped peers, they are more vulnerable to experimentation and substance abuse. Fox and Forbing (1991) suggested that:

> The following preventive measures should be taken to counteract the vulnerability of students with LD to chemical abuse: 1. Education about drugs and their effects; 2. Affective skill building; 3. Development of recreational skills; 4. Appropriate modeling by adults; 5. Enhanced communication and support systems. (p. 26)

Because ADD seems to be an inherited, biochemical disorder that has an impact upon students, steps should be taken to ensure that students succeed in the academic arena, as well as becoming law-abiding citizens.

Interventions Used with ADD Children

Medication

The medications most commonly used for ADD students are methylphenidate (Ritalin), dextroamphetamine (Dexedrine) and pemoline (Cylert). Some children no longer need medication upon

reaching puberty but others continue to use medication through adolescence and even into adulthood (Pelham, 1986).

Phelan (1989) stressed that medications used for ADD are safe but that they should be monitored for possible side effects. If there is a serious behavior problem the child should continue medication in the afternoon, on weekends, and during the summer.

There are some children who show negative reactions to drugs and may also become more hyperactive or inattentive although 75% of ADHD children do respond favorably to medication (Garber et al., 1990). Because taking medication helps children to concentrate, think before they act, and reduce the tendency toward becoming distracted by outside stimuli, Hunsucker asserted that the only way to help an ADD child is with medication. There is no cure for ADD, but with medication afflicted children can perform their school work adequately. Reading and arithmetic output and accuracy are increased, disruptive behaviors are lessened, and on-task activities are increased for some students with medication (Gomez & Cole, 1991). However, Swanson, Cantwell, Lerner, McBurnett, and Hanna (1991) maintained that Ritalin and other drugs do not necessarily improve the ability of a student with ADD to learn, and less than 20% of those treated show improvement in the academic areas of mathematics, spelling, or reading. Swanson et al. (1991) were also concerned that some children treated with

stimulant medication may receive doses that produce cognitive toxicity. Gomez and Cole (1991) reported that 30% do not show improvement, and that the medication seems to have very little impact on reasoning, problem solving, and learning, i.e., cognitive ability. They voiced concern about the children and others in contact with them thinking that without medication the children with ADD/ADHD are unable to control their behavior. These researchers indicated that parental belief will influence not only the way the parents handle the children, what the teachers expect of them, but also the children's self-perceived efficacy.

Treatment Alternatives or Adjuncts

An alternative to medication for children with ADHD is a behavior program that is individually conceptualized for each child with the mothers being trained as adjunct therapists. There is some evidence that such programs can lead to an improvement in classroom work completed, grades achieved, self-control, and disruptive behaviors. Using three interventions, i.e. stimulant medication, antidepressant medication, and behavioral treatment, it was found that the behavior program was not a sufficient treatment without medication (Gomez & Cole, 1991).

Other researchers consider Cognitive Behavior Therapy (CBT) as a viable adjunct treatment to medication, behavioral

management, parent counseling, and tutoring (Whalen & Henker, 1986). Gomez and Cole (1991) also focused on cognitive training programs and found that they were not significant alternatives to medication. Abikoff (1991) reported the same findings as Gomez and Cole (1991) and further reported that behavior can be altered if children are trained in interpersonal or social problem solving.

Blanton and Johnson (1991) discussed relaxation training as an intervention procedure with ADHD students. They stated that:

> Relaxation training assumes that students with ADHD can use their natural biological processes and through self-regulation training learn to attend and learn greater control over their behavior. This relaxation state may be induced by various techniques. These include progressive relaxation, ... breathing exercises, ... visual imagery, ... and biofeedback techniques. (pp. 79-80)

Children who were trained in biofeedback were able to stay on task better than those in other treatment programs. Because many schools have computers, Blanton and Johnson (1991) suggested that the use of this technology may become a practical intervention.

Classroom Intervention

The first step to determining classroom interventions is often identification of a child's learning differences. The State of Illinois does not use ADD as a separate classification. In a memorandum to Directors of Special Education, Lieberman, Assistant Superintendent, Department of Special Education, Illinois State Board of Education, wrote that the United States Department of Education did not include ADD as a separate category in the Individuals with Disabilities Education Act (IDEA) for the following reasons: (a) children with ADD may be eligible for services under Specific Learning Disabilities or Seriously Emotionally Disturbed; (b) they may be eligible under Other Health Impaired; (c) students may be covered under Section 504 of the Rehabilitation Act of 1973; (d) school districts are responsible for evaluation of children who they suspect may need special services; (e) if an ADD child is determined eligible, an IEP needs to be prepared; (f) the parent may request a due process hearing if disagreement about eligibility arises; (g) an IEP must be prepared if the child is handicapped and falls under the criteria of Section 504; and (h) districts must abide by procedural safeguards specified in Section 504 (Gail Lieberman, personal communication, November 8, 1991).

However, many school administrators are now concerned that they will be involved in educational malpractice lawsuits if they do not develop appropriate policies, procedures, and strategies for the ADD students (Essex & Schifani, 1992). These would include: (a) making certain that trained medical and psychological professionals are involved in diagnosis; (b) not allowing teachers to label students without supporting evidence; (c) making sure teachers recognize and understand characteristics and complexities of ADD; (d) developing and monitoring polices and procedures involving classification that are legally defensible; (e) involving parents, teachers, and school officials in policies that tell ADD students what is acceptable appropriate behavior; (f) quickly responding to parents's inquiries regarding practices and policies; (g) developing alternative strategies and plans based on anticipated disruptive behavior that are legally defensible; (h) making sure ADD students are treated as individuals; (i) making sure there are support systems; and (j) stressing positive behavioral outcomes when giving feedback; students should know proper behavior is an expectation not an exception.

Parents may be unable to receive the services they believe are necessary for their ADD student. If this is the case, Silver (1984) recommended that the family hire a private special

education tutor who, in turn, will be in contact with the regular classroom teacher. If this arrangement does not seem beneficial for the child, the family might consider placement in a private school designed to work with children with this particular disorder.

Kindergarten teachers can be alert for signs of ADD and/or ADHD and begin intervention so that the child can feel successful and accepted by his peers. With this early intervention, the child diagnosed as having ADD will have a better chance of staying in a regular classroom and being accepted by his peers (Barbin-Daniels, 1992; Osman, 1982; Wender & Wender, 1978).

Teachers may try different interventions. It is important for teachers to deal with the antecedents of behavior and then focus on managing the consequences of the behavior of the ADHD child (Abramowitz & O'Leary, 1991). Abramowitz and O'Leary mentioned contingent teacher attention, token economies, home-school contingencies, group contingencies, peer-mediated interventions, time-outs, and reductive procedures as viable treatment modes.

It is important that teachers make a brief note of strategies that they have attempted. If one intervention does not work, they can make a new assumption regarding the problem and try a new intervention. It is important that the teacher understand the

needs of each particular child in order to intervene appropriately (Jones, 1991). It is important to know what activities ADD children enjoy and what they value most in life. From these lists a teacher can devise interventions suited to each individual. Tobin (1991) listed ten needs of the child, i.e., acknowledgment, nutrition, communication, socialization, touch, humor, physical activity, structure, relaxation, and encouragement, and gave suggestions how to satisfy these needs.

Although studies conducted with adults and normal children indicate that the time of day has an effect on problem solving, "[p]erformance fluctuations have not been studied for pupils with special characteristics" (Zagar & Bowers, 1983, p. 337). Zagar and Bowers (1983) observed 43 ADHD pupils and found more interference, off-task behavior, noncompliance, and minor motor movements in the afternoon than were observed in the morning. The fluctuations in adults, normal children, and ADHD pupils were not attributable to fatigue or boredom. The suggestion made in this research is that overlearned, repetitive tasks, and difficult problem solving be done in the morning, and physical education and recreational classes in the afternoon. If this pattern is followed, the ADHD children are more likely to absorb the material being taught.

Specific techniques may also be employed for instruction. Because ADD children learn differently, the *Success* reading and writing program has made it possible for these students to succeed in regular classrooms (Smyth & Bebensee, 1983). With this program the teacher gives personal attention to the students. A twenty-minute period is set aside each day for journal writing. Twenty-five minutes each day are devoted to reading books that the students select. Children have a literature-sharing time and regularly meet with the teacher to talk about their books. They are also responsible for writing opinions on the books. Each day the students discuss current events, read the newspaper or a magazine to select vocabulary words and learn more about the topics discussed. Each student then discusses a word that was chosen, explains its meaning, and shares information about the news story. The program emphasizes study skills. The teacher selects the topics; the students select the subtopics. Research is done in committees. ADD children succeed because the program is structured and has a multisensory approach (Smyth & Bebensee, 1983).

"School-wide discipline programs will not meet the need of troubled children because they will be forever in detention or will be expelled from school by the fifth grade" (Tobin, 1991, p. 166). The unacceptable behavior should be described in a way

that the child can view it constructively. Describing the unacceptable behavior may help the child to see how the behavior affects others.

Further, children need to be motivated so that they will be interested in their school work. When they begin to fail this is when they start trying to amuse themselves by engaging in disruptive and inattentive behaviors. Some of the ADD students may be bored because the work is not challenging and exciting. The work the teacher is asking the child to perform may be well below the child's ability (Coleman, 1988). Wescott (1991) suggested that students can be motivated by drawing the day's schedule in stick figure cartoon style or by singing the schedule or a lesson.

The use of computers may be one solution for keeping students motivated. Computers may keep students on task longer, as well as give them privacy when exploring concepts and gaining skills. While using a computer, students are presented with random and unpredictable events. This tool can be utilized for regular, academic, and social situations. Not only may the use of computers improve the attention span of the students but also it may promote a spirit of cooperation and peer tutoring (Terwilliger, 1986).

It is important not to expect normal behavior from an ADD child, and measures should be taken to ensure the student's success in the classroom. Phelan (1989) suggested that the student's desk be placed near the teacher to approximate a one-on-one situation, that the classroom be structured, and that the student be distanced from distractors as far as possible. Phelan also proposed that the teachers should request that the child: (a) has his desk top organized, (b) maintains eye contact when instructions are given, (c) be aware of a secret signal between teacher and student, (d) has an assignment sheet or notebook, and (e) takes home a daily sheet to the parents. Other advice given by Phelan was: (a) the work be divided into small increments, (b) the child be rewarded for appropriate behaviors, and (c) the child be allowed to legitimately move around the classroom and/or school. Teachers should capitalize on the child's strengths and apply discipline clearly (Phelan, 1989).

It is the contention of Tremblay et al. (1992) that treatment for the disruptive behaviors of boys begins when they enter school in an effort to stem adolescent antisocial behavior, which, in turn, can lead to delinquency. Other researchers concur (Kramer, 1986; Szumowski et al., 1986; Walker et al., 1987; Hunsucker, 1988; Garber et al., 1990; Moffitt, 1990).

Gordon (1991) suggested that " . . . . no more than 30-45 minutes of homework for ADHD children in the elementary grades, and no more than an hour or so for older children" (p. 132) be assigned. If a large project will be due, the teacher should advise the parents so that the project can be worked on in steps and the teacher can check the progress intermittently. He also suggested that care be taken not to overburden these students with dittos. They need materials that are interesting and hold their attention. Gordon also gave suggestions for the "ideal" classroom for an ADHD child and mentioned the qualities for the "ideal" teacher for an ADHD child.

Even selection of educational materials makes a difference for students with ADD. Zentall, Falkenberg, and Brunton (1984) tested adolescents with behavior and attention difficulties while performing repetitive copying tasks. They found that their subjects had less errors on new learning tasks when presented with colored letters as opposed to black letters.

Reinforcements are also important to youngsters with ADD. Ingersoll (1988) gave examples of a currency-based token economy, the happy face reinforcer, and contracts that can be used in a classroom. Because unacceptable behavior cannot be overlooked, it is necessary to have some form of discipline and control. Ingersoll stressed that the teacher not insult the child's self-

worth and human dignity. An explanation is given of using "time out" and other preventive strategies.

One teacher in Broward County said that children become more productive during the school day if she visits them, gives them hugs, encourages them, and gives them pep talks. She stated that it is important that they be given this kind of attention because many grow up with negative self-images and destructive behaviors (Meade, 1991).

Because self-esteem is important, social skills training is also critical for children with ADD. Peer play groups are one way to make a positive impact on these children (Wells, 1986). McCall (1989), however, observed that when ADD children are placed in play groups with non-ADD children the non-ADD children are soon complaining about the performance of the children with ADD. This would indicate that simply placing children with ADD with non-ADD children is insufficient. Direct intervention to facilitate relationships is required.

Conclusion

In conclusion, some researchers have demonstrated that children with ADD and/or ADHD are at risk for developing serious problems in adulthood if there is not early intervention. Their low self-esteem and low self-concept can contribute to antisocial behavior in many of these children. Some researchers have also

demonstrated that low reading scores have been identified in children classified as having ADD and delinquency. It is important to discover the best ways of intervening in the classroom to prevent the behavior problems of ADD children from escalating. If further research supports findings obtained in this study, special and regular education teachers who are involved in the teaching of children identified as having ADD and/or ADHD could immediately implement the practices found to be effective by other teachers. Putting these practices into action could save these children from being misunderstood by parents, teachers, peers, and friends, and aid in the development of the child into a well-adjusted adult and member of society. Hawkins, Martin, Blanchard, and Brady (1991) stressed that schools should offer extensive preservice and inservice training to teachers in order to bring about positive changes in ADD children. They also maintain that this training will benefit not only children with ADD but also other students.

CHAPTER III

DESIGN OF THE STUDY

The purpose of this study was twofold: to identify a set of classroom practices perceived to be effective interventions with students diagnosed as ADD and/or ADHD, and to elicit the advice special education teachers would pass along to regular educators with ADD and/or ADHD students in their classrooms. The following describes the methods for achieving the purpose.

Setting

The sample was drawn from special education teachers in the State of Illinois, with the exception of the City of Chicago. (The list of special education teachers for the City of Chicago was not available.) Teachers were not asked to include their names or schools on the response sheet.

Sample

The researcher drew a random selection of three hundred special education teachers in the State of Illinois. Special education teachers were chosen for this study, because it is assumed that they have knowledge of children with ADD and/or ADHD. The list of all special education teachers in the State was provided by the Illinois State Board of Education (see Appendix

A). Every sixteenth person, starting with a randomly chosen first selection, on the list was chosen as a subject.

Instrumentation

The method of information collection was a questionnaire constructed by the researcher. The first part contains general questions regarding the teaching experience and attendance at classes or workshops focused upon ADD/ADHD. The second part is comprised of questions about what the teacher considers the most effective practices for classroom intervention in the areas of Antecedent Intervention, Contingency Management, Cognitive-Behavioral Management, and Social Skills. In the third part the teachers were asked for the advice they wish to give regular educators for intervening with a child diagnosed as having ADD/ADHD in their classrooms (see Appendices B & C).

Pilot

A pilot administration of the survey questionnaire was given to three special education teachers of convenience and six graduate students in the same program as the researcher. These participants were asked to comment on the design and content of the instrument. Their comments have resulted in modifications which are represented in the current form of the instrument which was used. One change was in the second question. The words "(or

what is the total number of students on your caseload)" were added to provide further clarification. The word "other" was inserted at the bottom of the first page to signal additional questions.

Prior to the pilot administration of the survey questionnaire, the following changes were made to the original questionnaire:

1. In question 1, "PreK, 9, 10, 11, 12" were added.

2. A question that asked "Do you think that you are knowledgeable about ADD and/or ADHD?" was eliminated.

3. In question 4, the words "any of the following regarding ADD and/or ADHD? (Check all that apply):" were added.

4. The instructions for completing the second part were clarified.

5. Under "Social Skills" the words "Suggested Interventions" replaced "Please explain."

6. The heading "General Suggestions" was added on page 2.

Analysis of Data

The data was analyzed by preparing frequency distributions of the responses to each item and tabulating them using percentages. The responses to the open-ended items are reported in narrative form in the next chapter.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this study was to contact special education teachers for their input on effective practices for intervention with ADD/ADHD students. The data collected to answer the questions was analyzed and is presented in tables and narratives. The first part deals with the results of the general questions regarding the teaching experience and attendance at classes or workshops focused on ADD/ADHD. The second part focuses on the effective practices for classroom intervention in the areas of Antecedent Intervention, Contingency Management, Cognitive-Behavioral Management, and Social Skills. The third part summarizes the advice the special education teachers wish to pass on to regular education teachers as well as any other comments they made.

Three hundred questionnaires were mailed. Eleven surveys were returned with an indication that the teachers were no longer in the field of special education or that they were no longer at the school where the questionnaire was sent. One hundred eighty-three teachers completed the questionnaire. This constitutes a 61% response rate.

In the first question, the teachers were asked what grade level(s) they were currently teaching. The results are indicated below in Table 1.

TABLE 1
Grade Level Currently Being Taught

Grade Level	Responses	Grade Level	Responses
PreK-8	1	5	1
K	1	5-6	3
K-1	1	5-6 & 8	1
K-2	1	5-7	1
K-2, 5	1	5-8	2
K-3	6	5-12	1
K-4	5	6	2
K-5	6	6-7	1
K-6	10	6-8	8
K-8	6	6-9	2
Dev.1st	1	6-12	1
1	1	7	5
1-2	2	7-8	10
1-3	9	7-9	2
1-3, 5	1	7-12	3
1-4	6	8	2
1-5	6	8-12	1
1-6	4	9	1
1-8	2	9-10	2
2	2	9-11	2
2-3	2	9, 10, 12	1
2, 4, 6, 8	1	9, 11, 12	1
2-5	1	9-12	24
2-6	2	10	1
3-4	3	10-11	1
3-6	4	10-12	3
4-5	4	11-12	1
4-6	10	No Response	1
		n =	183

In the second question, the teachers were asked to indicate how many students they serve in a week or the number of students in their caseloads. Thirty-six percent of the teachers answering have a caseload of 1-14 students. Twenty-nine percent of the respondents service 15-19 students. Sixteen percent of those answering service 20-24 students. Four percent have 25-29 students in their caseloads, and fourteen percent service thirty or more students per week. A summary of the responses is in Table 2.

TABLE 2

Number of Students Served in a Week
Or Total Number in Caseload

No. of Students	Teachers Responding	Percentage
1-14	66	36%
15-19	52	29%
20-24	29	16%
25-29	8	4%
30+	26	14%
no response	2	1%
n =	183	

The teachers were then asked to provide information regarding the number of years they have taught on a full-time basis. Thirty-eight percent of those replying have taught for 15 or more years. Twenty-one percent have been full-time teachers

for 11-14 years. Nineteen percent of the respondents have taught seven to ten years. Thirteen percent of the teachers replying have taught for four to six years, and nine percent have taught on a full-time basis for one to three years. A summary of this information is presented in Table 3.

TABLE 3

Years of Full-Time Teaching Experience

No. of Years	Teachers Responding	Percentage
1- 3	16	9%
4- 6	23	13%
7-10	34	19%
11-14	39	21%
15+	70	38%
No Response	1	
n =	183	

The teachers were then asked whether they had attended classes or workshops/seminars on the subject of ADD/ADHD. The total number of responses in this category is higher than 183, because some teachers indicated they attended classes and workshops/seminars. Fifteen percent of the teachers did not respond to this question. Three percent indicated that they have not attended any classes, workshops or seminars. Twenty-seven percent responding have attended some classes related to ADD/ADHD,

and eighty percent have attended workshops/seminars pertaining to this subject. Hours listed as "unknown" are those where the teacher simply inserted a question mark. Tables 4 and 5 indicate the breakdown on this question.

The teachers were then asked to respond to various antecedent interventions. They were told to choose all answers which applied. The first question in this category asked what they found to be the most effective desk placement. Many of the teachers checked two or more categories. The greatest percentage of responses (68%) indicated that seating next to the teacher is the most effective. Forty-six percent of the respondents seat students in rows, and twenty-eight percent utilize cluster seating. The results of this question are summarized in Table 6, and various responses to this question are itemized in Appendix D.

TABLE 4

ADD/ADHD Classes Attended

No. of Hours	Responses
3	11
4	3
5	1
6	9
8	2
9	2
10	2
12	3
15	1
21	1
Hours Unknown	14
n =	49

TABLE 5

ADD/ADHD Workshops/Seminars Attended

No. of Hours	Responses
1	4
2	9
3	21
4	17
5	10
6	8
8	7
9	3
10	10
12	5
13	1
15	14
20	1
20+	6
24	2
24+	1
25	1
30	2
Hours Unknown	25
n =	147

TABLE 6

Desk Placement

Type of Placement	No. of Responses	Percentage*
Seating next to teacher	124	68%
Seating in rows	84	46%
Seating in clusters	52	28%
Seating in circles	16	9%
Semi-circles or U shape	5	3%
Carrels	3	2%
Off by self	2	1%
n =	286	

* Respondents may have indicated more than one configuration, thus total percentage exceeds 100%.

Teachers were then asked to respond to the type of class that they deemed most effective for a student with ADD/ADHD. One hundred seventy teachers responded to this question. Sixty-six percent of the teachers believe that students with ADD/ADHD should be placed in a special classroom setting. Thirteen percent feel that these students should be in the regular classroom. However, 19% of the teachers consider that these students are best served in both a regular and special setting. The results of this tabulation are summarized in Table 7.

TABLE 7

Classroom Setting

Type of Classroom	No. of Responses	Percentage
Special	113	66%
Regular & special	32	19%
Regular	22	13%
Resource room	2	1%
Regular/team taught	1	1%
	n = 170	

The teachers were further asked what they found to be the most effective interventions regarding classroom structure. Again, the teachers could choose as many items as they wished. The average teacher checked four items in this category. More than 70% of the respondents found that dividing work into small pieces, having the students prepare assignment sheets or notebooks, and letting the child move around during the day were most effective. Sixty-seven percent replied that having a highly structured setting was effective. Having the students organize the tops of their desks, as well as eliminating distractions, was suggested by more than 50% of the teachers for structuring a classroom. Table 8 gives a summary of responses to this question. Many comments were received from teachers regarding the structure of setting, and these comments are contained in Appendix E.

TABLE 8

Structure of Setting

Ways to Structure the Setting	No. of Responses	Percentage
Dividing work into small pieces	144	79%
Having students prepare assignment sheets or notebooks	[illegible]	75%
Letting child move around during the day at appropriate times	130	71%
Structuring the setting highly i.e. things handled and laid out the same in terms of time and place	122	67%
Organizing top of desk	99	54%
Eliminating distractions	95	52%
Increasing stimulation through addition of color, shape and texture	28	21%
n =	755	

(Note: Teachers responding: 183; total exceeds 183 and 100% as respondents could indicate more than one selection.)

In the next category, the teachers were asked for what they consider to be the most effective intervention practices dealing with contingency management. Three teachers chose not to answer questions in this category. There were eight items in this classification. An average of four items was marked by each respondent. Ninety percent of the special educators indicated that they employ nonverbal feedback when working with students with ADD/ADHD. Giving calm, firm, consistent and immediate reprimands is viewed by 83% of respondents as effective. Praising appropriate behavior and ignoring inappropriate behaviors are useful for 78% of the respondents. Over 45% of respondents find it constructive to give time outs, use token economies and prepare a daily sheet to send home to the student's parents describing behavior and academic performance. A complete tabulation of this area of the questionnaire is found in Table 9, and other comments made by the teachers in this area are in Appendix F.

TABLE 9

Contingency Management

Types of Management	No. of Responses	Percentage
Giving nonverbal feedback such as nods, frowns, smiles, pats of approval	162	90%
Giving calm, firm, consistent and immediate reprimands	150	83%
Praising appropriate behavior and ignoring inappropriate	137	76%
Giving time out	86	48%
Using token economies	81	45%
Preparing a daily sheet to send home to parents describing behavior and academic performance	80	45%
Using peer-mediated reinforcement	50	28%
Using reductive procedures based on reinforcement	31	17%
n =	777	

(Teachers responding: 180)

Twenty-two percent of the teachers did not respond to the category dealing with cognitive-behavioral interventions. Several educators responded that they use both methods indicated on the questionnaire. Teaching self-monitoring techniques is a method favored by 88% of the teachers, while 49% employ the teaching of self-instruction techniques. A summary is found in Table 10, and additional comments on this intervention are in Appendix G.

Table 10

Cognitive-Behavioral Intervention

Techniques Taught	No. of Responses	Percentage
Self-monitoring	124	88%
self-instruction	70	49%
	n = 194	

(Teachers responding: 143)

The special education teachers surveyed commented on intervention strategies that they incorporate in attempting to improve the social skills of a student with ADD/ADHD. The strategies range from the social worker conducting group sessions with the students to the use of games. The "skillstreaming program" was mentioned as being effective. Several teachers also remarked that they involve the student in problem solving situations. They discuss what is inappropriate and ask the student to name an appropriate behavior. Role-playing is also used by many of the special education teachers. These comments are registered in Appendix H.

This researcher also asked for advice that the special educators would give to regular education teachers who have a student(s) with ADD/ADHD in their classroom. Some of the most frequently mentioned "bits of wisdom" are to "be consistent," "be structured," "be patient," and "communicate" with parents, other

teachers and the student himself. It was frequently mentioned that teachers should have a sense of humor. In order to learn more about the child with ADD/ADHD, it was suggested that the teacher take classes, attend meetings of organizations primarily concerned with ADD such as CHADD and realize that the child does not choose to act inappropriately. These comments are included in Appendix I.

Appendix J contains those commentaries that the special educators shared under the category "other comments." Many of the teachers advocate the use of medication for children diagnosed ADD/ADHD. Several mentioned the importance of letting the child know that you care about him/her. Nonverbal approaches were also indicated to be effective strategies. Every comment is included. Many respondents have stated that there is not one intervention that will work with every child. Every child is unique, and the teacher may have to try many techniques before finding the one that will work for the student with ADD/ADHD being served. Perhaps, if some suggestions were omitted, the very ones that would have been beneficial for a particular child would have been lost to the reader.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER STUDY

Summary

In summary, 183 of 300 of those surveyed responded. The respondents ranged in assignments from pre-kindergarten to twelfth grades. From one to fifteen or more years of teaching was the experience range of the teachers. Many respondents attended classes and/or workshops/seminars regarding ADD/ADHD.

Responding to the question regarding effective desk placement, 68% of the respondents favored seating next to the teacher. Seating in rows was recommended by 46%, and seating in clusters was suggested by 28% of those replying to this question.

The next question asked of the special educators was the type of classroom setting they favored for children with ADD/ADHD. Sixty-six percent preferred a special education setting. A combination of regular classroom and special education classroom was indicated to be most effective by 19%, and 13% stated that the students with ADD/ADHD should be placed in a regular classroom.

Teachers were then asked to respond to various techniques that they found effective in structuring the setting for children with ADD/ADHD. Over seventy percent of the respondents recommended that the student's work be divided into small pieces,

that the students prepare assignment sheets or notebooks, and that the student move around during the day at appropriate times.

Taking into consideration various types of contingency management that might be deemed effective for the student with ADD/ADHD, 90% of the respondents preferred nonverbal feedback such as nods, frowns, smiles, and pats of approval. Eighty-three percent of the special educators believed in calm, firm, consistent and immediate reprimands. Many respondents regarded praising appropriate behaviors and ignoring inappropriate behaviors as effective contingency management practices.

This researcher was interested in cognitive-behavioral interventions for the student with ADD/ADHD. Eighty-eight percent of the respondents replied that they taught their students self-monitoring techniques.

The teachers were asked to comment on the interventions they used for reinforcing social skills. All comments are listed in Appendix H. This researcher was also interested to learn what advice a special education teacher would give a regular education teacher who had a student with ADD/ADHD in the classroom and also any other comments that special educators wished to make. These comments are contained in Appendices I and J respectively.

Conclusion

Because 61% of teachers surveyed responded to the questionnaire, it is deduced by this researcher that the question of what are the effective ways of handling a student with ADD/ADHD is relevant at this time. With a combined number of years of teaching experience no less than 1,825 years and a combined attendance at workshops, seminars, and courses of no fewer than 1,283 hours, the suggestions from these practicing special educators should be taken under advisement. Review of their actual comments, especially those in appendices I and J, are priceless.

Regardless of the number of years of teaching experience, teachers are looking for constructive ways to manage students with ADD and/or ADHD. The teacher respondents appear to be very optimistic that with patience, understanding, and sometimes even a bit of humor these students will succeed in the classroom.

Recommendations for Further Study

Longitudinal studies following students to determine if intervention curbs drop-out, delinquency, and drug abuse might be conducted in the future. Future research might also be to follow-up with regular education teachers to get their feedback on the usefulness of these strategies.

Significance of Study

This study is important, because 3-5% of students, or roughly one in every classroom, has been diagnosed ADD and/or ADHD. Previous research has shown that children with ADD and/or ADHD are at risk for conduct disorders. It is thought that if support is given to these children there will be a decrease in juvenile delinquency, drug abuse, and school drop-out rates (Hunsucker, 1988). In order for these students to be motivated to stay in school, educators need to know the effective ways to intervene in the classroom. This study is an attempt to determine what intervention strategies special educators cite as effective modes to use with ADD/ADHD children.

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APPENDICES

Appendix A

Letter of Request for Addresses for Use in Survey

April 1, 1992

Dr. Cindy Terry
Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777

Dear Dr. Terry:

I am a graduate student in Learning Disabilities at St. Xavier College in Chicago. I am planning on doing my Master's Thesis on the subject of ADD, and Mr. Robert Abbott of the Waukegan Public Schools suggested that I write you for information on ISBE's paper on ADD.

Mr. Abbott also suggested that I ask you how I might obtain the names and addresses of L.D. teachers in Illinois so that I might ask if they would participate in my gathering of information for the thesis.

Thanking you in advance, I am

Sincerely,

Barbara L. Askew

Appendix B

Letter to Teachers

November 5, 1992

Dear Teacher,

I am currently enrolled in the Master's Program in Learning Disabilities at Saint Xavier University. In order to fulfill my graduate requirements, I must prepare a master's thesis. The purpose of my thesis is to find out what special education teachers in the State of Illinois find are effective practices for intervention in the classroom for students with Attention Deficit Disorder and/or Attention Deficit Hyperactivity Disorder (ADD/ADHD) and also what advice they might give regular education teachers for dealing with this student population.

Attached you will find a questionnaire. Please complete same and return it to me in the stamped, self-addressed envelope by (date).

Your replies will remain anonymous. Thank you for your cooperation which is greatly appreciated.

Sincerely yours,

Barbara L. Askew

Thesis Advisor:
Dr. Margaret K. Carroll
Saint Xavier University
3700 West 103rd Street
Chicago, Illinois 60655
312-298-3212

Please return questionnaire by December 3, 1992.

Appendix C

Questionnaire

1. What grade level(s) are you currently teaching?
   PreK K 1 2 3 4 5 6 7 8 9 10 11 12
2. How many students do you serve in a week (or what is the total number of students on your caseload)?
   1-14 15-19 20-24 25-29 30+
3. How many years of full-time teaching experience have you had?
   1-3 4-6 7-10 11-14 15+
4. Have you attended any of the following regarding ADD and/or ADHD? (Check all that apply):
   _____ classes _____ number of hours
   _____ workshops/seminars _____ number of hours

The following is an abbreviated list of possible interventions for use with children with mild disabilities. What do you find are effective practices for intervention in your classroom for students with ADD and/or ADHD. Check all that apply in each section. In addition, cite any other interventions you find effective.

Antecedent Intervention

Desk Placement

_____ seating in clusters _____ seating in circles
_____ seating in rows _____ seating next to teacher

Type of Class

_____ regular classroom _____ special classroom

Structure of Setting

_____ eliminating distractions, i.e., placing children in study carrels and using ear-plugs
_____ organizing top of desk
_____ structuring the setting highly, i.e. things handled and laid out the same in terms of time and place
_____ dividing work into small pieces
_____ having students prepare assignment sheets or notebooks
_____ letting child move around during the day at appropriate times
_____ increasing stimulation through addition of color, shape and texture
_____ other (please explain)_____

(over)

Contingency Management

_____ giving nonverbal feedback such as nods, frowns, smiles, pats of approval
_____ praising appropriate behavior; ignoring inappropriate behavior
_____ giving calm, firm, consistent and immediate reprimands
_____ using token economies
_____ preparing a daily sheet to send home to parents describing behavior and academic performance
_____ using peer-mediated reinforcement
_____ giving time out
_____ using reductive procedures based on reinforcement
_____ other (please explain) _____

_____

Cognitive-Behavioral Interventions

_____ teaching self-monitoring techniques
_____ teaching self-instruction techniques
_____ other (please explain) _____

_____

_____

Social Skills

Suggested Interventions) _____

_____

General Suggestions

The advice I can give to regular education teachers with ADD and/or ADHD student(s) in their classroom is:

_____

_____

Other Comments

_____

_____

Appendix D

Responses Regarding Desk Placement

* Have student sitting on the side but vision to the instructor is clear
* Seating at large tables, clear of all objects, except what is being taught at that time
* Anything different or out of the ordinary causes a reason for problems; NEVER sitting next to teacher at h. s. level. They love to use this as focus of attention!
* Front row, if possible
* Individual placement with a table for each student. This gives them "space"
* Tables for projects
* Circles in Resource Room only
* Dependent on child and class activity
* In my resource room we all sit together at 1 or 2 tables. I try not to let 2 children with ADHD sit directly across or next to each other.
* Or towards the back - but teacher must move near him often - but other kids aren't distracted.
* Front of the room

Appendix E

Comments Regarding Structure of Setting

* Take photo of clean desk (inside) - tape on lid to model
* Re: assignment sheets: kids verbalize tasks to teacher
* My experience leads to shy away from letting the child move around. He usually disturbs others. I require that my class must work quietly - for the distractable but also regular LD need less distractions also.
* 1:1 to keep on track. Set timer to mark on-task behavior.
* Repeating everything; presenting material many different ways - visually, written; lots of computer work; use lots of pairing with other students for cooperative learning - excellent thing to do; give them opportunities just like other children.
* Many examples - I teach science and social studies - many varied activities.
* Behavior management rules laid out and followed through.
* Work with teacher during free period for talking and developing rapport. Set up limits and consequences for the other students who laugh at or "set up" the ADD student.
* These intervention techniques work only very minimally as the ADD children really cannot control themselves. I have seen medication make a major difference in several children's lives.
* Short assignments - immediate feedback, concrete rewards - points, stickers, etc.
* Changing type of assignment every 20-30 minutes
* Parents signing assignment sheets, stressing student's responsibility for problem solving, cooperative grouping
* Repeat directions to tasks; take daily notes
* Checking and initialing assignment notebooks - checked and signed by parents; phone contact with parents - conference as necessary (with team teachers)
* Use a timer to set goals
* Material organized in school bag so that all necessary materials are in class and on time
* Using sensory-motor-tactile type of instruction. Keep him busy.
* As an LD Resource teacher, I mainly work one-on-one with my students.
* Organize inside of desk
* Visual signal or auditory cue that is predetermined so student knows he/she is to focus, or get back on task, when used.
* Let the students work w/ each other as I oversee the work being done in groups. I also use color Xerox paper to work with children. They seem to draw attention to the colors. Great way to color code work assignments at Jr. High.

* Away from door, window; placed with a quiet, well-organized, structured student.
* Programs that use cognitive abilities over rote memory. Systematic programs that build on prior knowledge.
* Hands on learning as much as possible
* Add movement to some lessons; also a light touch to hand or arm to get the child back into focus
* Proximity control, re-direction to task, role modeling
* Escorting student to class: resource room for study hall for 1 to 1 help on incomplete assignments
* Helping at end of day to organize completed work and homework
* Reduce assignments: some increase in bathroom/drink breaks. I spend time with regular teachers explaining that "detentions" are not helpful- also parent consideration of medication.
* Allowing freedom to make comments, on the topic, throughout class.
* I have L.D. Social Studies classes of 7-12 students. I try to keep my ADD student either in front or isolated in the back of the room.
* Make assignments shorter or broken into smaller sections (10 questions on 1 page instead of 20)
* Carpeted rooms are quieter - stay away from pencil sharpeners, drinking fountains and open doorways.
* Minimize verbal representations; increasing active participation: (a) reading assignments that are interrupted with activities based on reading; (b) body movements in response to correct answers - stand up, turn around, etc.
* Clearly stated rules in a limited number (no more than 3) are helpful.
* They are seated in rows in the front of the room during work time - facing the chalkboard. During lessons, they are seated around a table or floor near me.
* Letting student work with and next to another student. Student should try to keep pace with partner and ask questions when needed.
* Not eliminating distractions all day, but child must know why - not that it's punitive.
* I have found that educators should realize that not one strategy is effective with all children. It is also helpful to realize that it's OK for a child to fidget or move around or talk through a problem. In some cases our behavioral expectations have to be lowered unless, of course, it hinders the learning of others.

* Need more parental involvement and caring. If students have not internalized the need to do homework or finish tasks and cannot/will not take responsibility to do this, it often won't matter because many parents are of no help with checking to see if work is done or if child needs help. Often assignment sheets are lost. Need to set up a routine on where the assignment sheet will be placed each afternoon when they leave school (i.e. in front of purple notebook).
* Have them help find the best way to organize their own materials and leave it that way. Give them their own space/area.
* Have a calendar visible to class on which everything in terms of change, etc. is listed. There is procedure for everything - even lining up.
* Use of computer to enhance/replace homework.
* One thing that works well is to offer the student an opportunity to control his own environment - knowing he needs to move around - pass to washroom, etc.
* Provide missing material to avoid delay in starting and finishing a task.
* Be physically close to student to provide positive feedback during independent activity. Buddy system - check each other's work/assignment notebook. Multi-sensory methods - visual clues as much as possible.
* Reduce number of students in small groups (2-3), seat at front of room and away from door or window.
* Do not place child with back to all other children - will constantly be checking out what is going on behind.
* Multi-sensory approach. Elicit home support. These children are very environmentally sensitive. We need to be aware of their level of distractibility, forced concentration, and the amount of effort and energy they use in trying to meet expectations.
* Use of timers.
* Mentor program; consistent discipline program - used in all areas where student participates.
* It is helpful to keep weekly grades so students can monitor achievement more often than at mid-term.
* Setting up cooperative groups.
* Positive reinforcement for following directions correctly (verbal comment).
* Messenger duties are good.

Appendix F

Comments Regarding Contingency Management

* These intervention techniques work only very minimally as the ADD children really cannot control themselves. I have seen medication make a major difference in several children's lives.
* Keep close contact with parents. Try to make a consistent behavior program at home and school.
* Contract written for a 2-3 week period with an agreed on award if achieved. This has been successful. Nonverbal feedback sometimes used but often they don't respond unless touched. Difficult to ignore inappropriate behavior because very often disrupts the whole class.
* Self-evaluation/problem solving sheets.
* Frequent phone contact with parents.
* Placement of teacher's hand on shoulder of student doing inappropriate behavior.
* Use of daily sheet home depends on parent! Some parents use the notes to beat the child!
* Tape recorder on during class; point system.
* Our school has a "Caught Doing Good" program. I use this as a reinforcement for good behavior.
* Regarding the daily sheet sent home to parents: goal sheet with points earned for achieving goals. Then a reward is given usually after 0 "good days."
* Reward to help younger children.
* I cannot ignore grossly inappropriate behavior. It is not fair to other students. Two warnings - then sent to Dean or "banished" to hallway. Invite student for lunch in my room - my treat.
* Interesting lesson.
* Taping reminders of good social behavior to desk.
* Reinstruction and/or questioning before child starts task to be sure he or she understands the task.
* Give extra time as needed; monitor behavior frequently - praise immediately good behavior; simplify directions; be consistent with instruction, consequences and rewards.
* For some students, parents' signature is required daily on sheet sent home.
* Only send home daily sheet if parents truly understand ADD.
* Regarding peer-mediated reinforcement: what I've seen is that this hasn't bothered the ADD child, even though it may be negative.
* We find allowing the very active students to chew gum during work time is helpful.

* At the h.s. level, I will sometimes use negative reinforcement. I will even send the student to the dean if his/her action merits it.
* Computer game time for completed assignments but sometime was always given for effort.
* Lessen workload at times; cover part of worksheet to limit visual stimulation.
* We frequently use behavior charts for each day (divided into N periods) and the child is rewarded w/ a sticker for a % of appropriate behavior (task completion, proper peer contacts, etc.).
* I use yellow, green and red cards to indicate behavior. They are rewarded at home for the yellow/green cards. Time out: as "regrouping technique - getting themselves "together" again.
* Use of point sheets for daily work culminating in special event every three weeks to use points, e.g. ice cream party, auction, etc.
* Assertive Discipline
* If you ignore it, the behavior often continues. Pats of approval - no touching. Progress reports to parents. Expect quality work - give encouragement and helpful advice and hints on a continuous basis. Give praise when the student has shown accomplishment with respect to behavior and academic work. Give grades for smaller segments of work.
* These kids aren't real good at reading body language. Re daily sheet: I do this in hopes some parents will come around if I keep this up, but I know these often go ignored by many of the parents. I use the phone. Keep a very calm, low-key atmosphere in classroom.
* Reductive procedures based on reinforcement are often hard to do in whole class time.
* Peer tutor to help organize and redirect, also to check assignments are written down for homework, etc., etc.
* Maintain a particular tone of voice, way of presentation. Explain in detail using appropriate language any changes in usual routine before they happen.
* At the end of every week those who have made their goal receive 1 can of pop (school donated) and refreshments (teacher donated). At the end of 9 weeks, the school pays for activities if student reaches 9 weeks' goal. Examples of activities are: popcorn and video, pizza and video, billiards at local Jr. College and Science Center in St. Louis.
* Send him with a note to the office just to provide in break in study time for student.
* Using rewards like stickers, no homework passes, time on computer, games.

Appendix G

Comments Regarding Cognitive-Behavioral Interventions

* Behavior modification programs are also very effective.
* Work on appropriate "group" behaviors so the student can function in regular classroom setting.
* I do teach both techniques but have not been very successful with most of my ADHD students unless medication is used.
* Instill pride in work and grades; let students decide "time out" intervals.
* Daily review of behavior checklist.
* You have to have the child first recognize the problem and admit it before change can occur.
* Cooperative learning! Private conferences with student to discuss accomplishments and areas in need of improvement.
* Study skills/ 1st letter mnemonics.
* Use 3x5 cards taped to desk. Give points for positives & negatives. Explain how.
* I've found that the ADD child (is) (can be) intelligent - but just needs that structure that says - this is due - if not, you fail!
* Student keeps graph of completed assignments and on-task behaviors.
* Bank system is monitored via a chart that the student completes. Every 10 min. he puts in a $ amount if he is following rules.
* Many "talking to oneself" ideas - role-playing.
* Using a timer set for short work periods along with setting goal for accomplishment during that time and a reward for compliance.
* Have structured checkpoints - give child time to verbalize expected behavior.
* Give cues to help organize. Ex. "this is like ..." I use looks, words, body gestures to communicate.
* They really need something that works for them which they can use in the classroom.
* Discussing problem on a one-to-one or with class if it involves everyone. Many of these students are also B.D. One procedures does not work for everyone.
* Strategies for Study - The Perfection Form Co. Making the Grade - The Perfection Form Co.
* I remind my students that they will listen better if their hands are quiet, their mouths are closed, and their eyes are on the person talking.
* Teach metacognition - self-reflection strategies for academics and behavior.

Appendix H

Comments Regarding Suggested Interventions for Social Skills

* Games involving communication skills and listening skills.
* Give a leadership role to student and work on behaviors to make it a positive experience.
* Peer tutoring situations (choose a student who is tolerant and not the same one each time).
* Modeling desired skills.
* Other children often reject the ADD or ADHD student, because they are always in trouble. Let other students know they can't always help what they do.
* Students are told what is not appropriate and have them name a more appropriate behavior.
* Role-play situations; teach social skills daily; teach self-esteem activities.
* We have group for a 40 min. period once a week with the social worker to talk about different issues - what's bothering them - mostly why are they in special ed.
* Counseling and discussion.
* Use of "skillstreaming" programming throughout school.
* Role playing with teacher/with peer.
* Analyze with the student a problem and how they could handle it better next time - brainstorm appropriate behaviors.
* Social skills curriculum - scripted "I can" statements.
* Use book "Skillstreaming the adolescent - modeling and role-playing."
* Problem solving situations - maybe role played, simulated, or actual problems. Students need to learn to process (think through logically) problems and their possible solutions.
* Small group discussions, social worker, peer groups, join school clubs, organizations.
* Use school discipline program - assertive discipline - positive-negative points work - remind students of what is school appropriate.
* Social work groups, team activities.
* Small groups; role play; written assignments.
* Point out negative behaviors - tell student or demonstrate what is socially appropriate.
* Role modeling, join things (teams, girl scouts, clubs), talking it out with someone.
* Let classmates talk about social skills - peer pressure.
* Scripting for conflict resolution, working on one behavior at a time.

* Teaching strategies to solve problems, i.e. making friends, self-esteem, using cooperative grouping, practicing using good manners.
* Skills for Growing Program used with entire class.
* Let him/her have leadership opportunities.
* Making them very concrete.
* Work with social worker; coordinate interventions for consistency.
* Discuss wrong behaviors - point out reasons & conseq.
* Class work involving lessons, discussions, worksheets, simulations.
* Develop relationship w/ student. At private lunches role-playing various situations so student can learn to troubleshoot.
* Be consistent with what is appropriate. Do not argue or accept anything less. You must show them directly what is wrong and have them explain why. They usually know and know what to do to correct. They do need help from us just like in the classroom to get through situations. (Prompts of some sort.) Having 2 students work together. I pick the partners to help develop social skills.
* Try to involve students in school/class activities to help develop social skills and self-esteem. Try to avoid situations which are very competitive. Find out what they are good at and build from that. Working in small group situations can prove beneficial.
* Get them involved in sports, plays, extra curriculars to experience success outside the classroom.
* Practicing appropriate responses to compliments and participating in everyday conversation.
* Parent training/peer monitoring/step training.
* Cooperative learning; peer coaching.
* Self-monitoring and gentle teacher reminders that other children do not want to be touched.
* Watch people around you for clues.
* Our social worker works with small groups and role playing.
* S.H.A.R.E. - S.L.A.N.T.
* Classroom points; overload of appropriate examples.
* Showing them appropriate tasks that they may use.
* Allow opportunities to speak and have some attention drawn to themselves - in an appropriate manner!
* Actually discussing what is appropriate and what is not.
* Do value judgments, small group work on appropriate behaviors.
* Pairing students to work on a fun exercise on the computer.
* Buddy system.
* I will impress upon a student what is proper and improper behavior.

* Reminding students to "stop and think" before making a decision - not to act on impulse.
* We have a 40 min. group time - problem solving session- write notes on board about 1 problem - read problem from board.
* Modeling and rehearsing appropriate social behavior - correcting poor behavior with "what if you had tried it this way?" - follow with modeling.
* Teaching self-instruction techniques to show correct behavior.
* Sometimes peer pressure works - other students tell students they can not work because his behavior is distracting.
* Role-playing - verbal awareness - talks with parents - talks with classroom teacher.
* My room serves as a cool-off room - student is allowed to come to my room when things are not going well in regular classroom or at recess. He comes in and immediately writes in a journal and then we talk about it. We emphasize how to handle the situation differently.
* Instruction in skillstreaming has helped with some behaviors but not with the attention deficit itself. It can improve functioning in some situations.
* Practice appropriate behaviors - have students write their behavior, why it was inappropriate, and what behavior would have been more acceptable.
* Lots of goals with visual reminders of achievements.
* Direct instruction in social work group.
* Verbal and non-verbal feedback. I stress catching the student being good or interacting appropriately.
* Allow opportunity to model and practice social skills in the classroom ("free time").
* In my situation, our building social workers work in this area.
* Model positive social skills and reward the student for doing them.
* Praise when they do a good job so student knows everyone has good traits. Working in groups facilitates socialization. It also helps students get to know one another and then they won't "pick" on the slow or hyperactive child.
* Use whatever works - these students don't all fit the same mold. What we learn from the textbook is different from what we experience in the classroom. Sometimes it's easier said than done.
* Role playing (such as in Skillstreaming the Elementary School Child), being a good role model and bombarding them with lots of appropriate behaviors is important.
* Small group play works best for me rotating active child. I also watch for positive behaviors and verbalize praise right then.
* Try to teach the "Golden Rule" (do unto others).

* Build a positive relationship with student - motivation for student becomes social in nature. He/she will work, because the student likes the teacher.
* Reduce impulse control through games: taking turns, waiting for others.
* Why Are You Calling Me L.D.? - Peekan Publications, Inc.
* Modeling, cooperative groups, social work intervention.
* Peer tutor, 1 on 1, small group activities.
* Speak with child prior to an event or situation (i.e. being in hallway during class change) to "set standards" or allow child to plan ahead.
* I often include another general education student with the group in the Resource Room so that the general education student knows what my students do and where they go - has had very positive results, especially when initiated at the K & 1st levels.
* School social worker leads weekly group that focuses on social skills.
* Children need role playing and problem solving techniques. Appropriate behavior and social response need to be discussed, taught and rehearsed.
* Reinforcing appropriate peer interaction.
* Educating regular classroom students and teachers what to expect and how they can help. Social work services.
* Modeling; small peer groups - friendship groups.
* Role play re issues common to grade levels.
* Social skills groups.
* Heterogeneous grouping.
* Use peer facilitators from high school.
* Role play, special seating.
* I'm still working on this one. The fights still prevail due to misread social situations.
* Find strengths of student and allow to work with younger student.
* I have used checklists for each period of the day with consequences and rewards spelled out in a contract type form.

Appendix I

General Suggestions for Regular Education Teachers Having Students with ADD/ADHD in Their Classroom

* Make parents aware and educated about ADD.
* Be consistent, structured. Use charts or reinforcers - whatever works. Stay in contact with parents in case medical intervention (Ritalin) is necessary.
* Seat in front of class - maintain eye contact frequently - or physical - touch - desk, student - connect.
* To be organized; have work ready; place student near teacher where they speak to readily be able; offer nods or touches to keep student on task.
* Learn more about ADD-ADHD; talk with student(s) to find out what works for him (them); be patient and remember that some ADD/ADHD students grow up to be outstanding, energetic leaders and well-functioning adults - filled with the drive so often needed to be unique in their adult lives.
* Call for all possible outside help. Use services of Special Ed. teachers, counselor, etc. - Do not tolerate any inappropriate behavior. Use consequences consistently.
* Lower expectations; modify assignments; have LD teacher modify assignments.
* Consult other resources like Special Ed. teacher, other professionals.
* Humor and a smile; let student know they have talents and utilize those talents!!! Know that you choose to be there for them.
* Be patient, firm and structured. Get immediate parent support.
* Lots of individual attention and involvement in outside interests that the students enjoy and can share.
* Keep communication constant between regular and special educators.
* Smaller assignments; counsel parents to seek medication; clear concise directions (use highlighting techniques, use overheard projector, use peer tutor); check frequently.
* Be consistent, organized and caring.
* Keep a very organized, structured classroom and routine where the child knows exactly what is expected. Consistency in everything.
* Be positive and consistent and firm. Develop a positive rapport with student. Develop trust and be honest. Never promise something you cannot follow through on.
* Sit students towards or at front of room (less distraction). Work should be small chunks.
* Make success possible rather than negative reinforcement.

* Be patient when dealing with this child. Most often parents have chosen to medicate which can help academic performance of students. Monitor any behavioral changes and document anything worth reporting to parents.
* Give the student the opportunity to move around occasionally. Do a lot of teaching near the student or by his/her side so you can use hand placement. Keep tone of voice down and even. Follow through.
* Provide structure. Help them organize their desk, materials, check their assignment notebook before going home; have pocket folders for each subject. Have clear rules, consequences and rewards.
* Get informed - go to CHADD meetings, read articles, become a resource, work with the LD teacher to explore interventions to help.
* Be consistent in whatever you feel most comfortable in implementing in your class.
* Talk to the parents about medical interventions. I have seen them work well.
* Use a study carrel, if possible, in the room. The regular classroom teachers and I use an assignment book to communicate between ourselves and home.
* Weekly/daily contact with parents, social workers, SpEd teachers, etc.
* Consistency.
* Structured class - student knows up front all expectations/consequences.
* Consistency is #1.
* Monitor child frequently for work quality/completion and behavior. Provide visual and auditory clues.
* Structure and positive reinforcement.
* Allow some freedom of movement - discuss situation with entire class - state and consistently stay within stated guidelines for permissible behavior.
* Be organized. Try to establish a routine for daily class procedure so students know what to expect. Try to remain calm no matter how frantic the situation becomes.
* Call name to bring back w/ classroom situations, touch on shoulder to follow along: pair with another student to help modeling.
* Value the children. Let them know that you care.
* Maintain structure. Be consistent and firm.
* Discipline through expectations same as other students; tolerance; attention (we tend to ignore them).

* Provide varied activities - quiet activity followed by activity w/ movement/ do not ignore inappropriate behavior - student must bear responsibility for his actions.
* It won't be easy - be consistent! Use the "1-2-3" approach - do not argue - they love to argue.
* Relax -
* Sit student near front of class. Use a study buddy. Assignment notebook. Break down assignments into small steps. Praise each small accomplishment.
* Get to know each individual child. Although there are similarities with ADHD students, each student is unique.
* Be patient, understanding, read and learn about ADD and/or ADHD. Use special educators as references.
* Keep them involved and busy participating in classroom activities.
* Keep an assignment notebook - initial if student completed work.
* Develop a sense of humor. Remain calm. Be patient.
* Frequently address the student by name (others also) during lectures in a non-questioning manner, e.g. Did you know, Paul, that 78% of the atmosphere is nitrogen?
* Be patient!! Remember them and keep them close. They'll never be absent!
* Keep communication open with parents and other professionals that work with the child. No matter how frustrating it is, don't argue with the student - stay calm. If you aren't seeing a difference in the child over a period of time, reevaluate the situation and try new methods.
* Modify the curriculum when needed. Wait for answers; teachers often don't give enough response time.
* Reduce stimulation in the environment. Reduce stress/workloads reduced.
* Be consistent and realistic with procedures and expectations of student's abilities and work from there progressing to a higher level.
* Place student's desk where you can best tolerate it. Use lots of physical cues, touch book or page discussing, touch child's shoulder or hand - be firm and consistent!
* Be patient; try to read about or attend classes on ADD/ADHD; don't give up - sometimes interventions need to be implemented for a longer period of time in order for them to start working.
* Try to place yourself in the ADD person's place. Start each day with a fresh start. Use visual clues. Use physical tapping clues. Be positive! You can use a peer to help the student if appropriate. Jr. High age is great!
* Parent intervention and cooperation is most important for school success.

* To try not to "lose it" - they have little or no control - look for the accomplishments.
* As I heard once - treat them as if they can't hear - make sure they understand what is expected of them.
* Be highly structured, be practical, have a lot of common sense, have a sense of humor.
* The tape entitled "1-2-3 Magic" is good to preview.
* PATIENCE! Learn what ADD truly is - don't assume the child is a behavior problem!
* Consider how this impacts other learning.
* Seat child near, call on frequently, make eye contract, use more than one modality, behavior mod. techniques, positive settings, make guidelines clear.
* Educate yourself on ADD and be aware of the children in your classroom who have ADD.
* Make allowances when possible, especially if the child has proven he can do the task.
* Good luck!
* Make things structured and allow for appropriate movement. Get rid of distractors on desk.
* Break up questions on worksheets - fewer per page.
* This is a physical problem; do not take this behavior personally.
* Develop a routine and stick to it as much as possible; provide feedback (pos/neg) as immediate as possible; reduce distractions, place near responsible well-behaved students as role models; keep things moving! These children have a hard time choosing/making choices when "free time" is given. Give them 2-3 choices to choose from (i.e. books to read, games, etc.).
* Be understanding, patient and willing to adjust the situation to help meet their needs.
* Remember their limitations and frustrations. Try to use positive (praising) comments for good behavior and notice the great outcome. Remember we all have bad days sometimes. Use of "stress" ball so kids can alleviate their frustrations without using classmates. (The kids love this!)
* Try to keep time structured, be as organized as possible.
* Always remember that the child isn't "bad." (S)he has a medical problem that requires patience, understanding, and more attention than a "normal" child. With all concerned parties working in cooperation, the child can be educated and the behaviors can be improved.
* Have student repeat and/or paraphrase assignment, concept, directions. Use short, concise sentences when teaching. Use Direct Instruction Method.

* I send out a note at the beginning of the year telling of student's strengths and some handouts telling teachers about ADD/ADHD and giving suggestions.
* Structure/consistency/use firm/unemotional control techniques. It is important for the teacher to remain claim and have a "flat affect" when disciplining an ADHD student.
* Reduce stimulation; be consistent.
* Build rapport and acceptance with student. Give student a "worth" within classroom. Use peer tutoring. Cut workload. Monitor closely. Remediate frequently.
* Try to have as much structure as possible and fewer distractions.
* Try to concentrate on one or two behaviors at a time. Praise these (ignore others unless totally inappropriate) until later. If you try to control or change everything at once, it's impossible! Peers can be very helpful - can be good leaders for the ADD student to emulate! Too many distractions in resource room if <u>everyone</u> is doing something different - who should he model?
* Keep situation structured, use calm voice, give cues that are known to student.
* Keep trying combinations of interventions until progress is made.
* Students do not transition well - give ample warnings before transitions - routines & structures are extremely important - be consistent.
* Give assignments in parts and then check. Walk around room and touch on shoulder or head as a reminder to return to work. Shorten assignments, i.e. do odd/even numbered problems or one side only or top of page, etc.
* Realize this student is and will be often difficult to handle. Avoid being hard on yourself. Realize there will be times they might need to be removed from group. Remember they are special children whose world moves a lot faster. Finally, because they demand a lot, the teacher of the ADD/ADHD child needs to establish an outlet for herself to keep ahead. I use the school social worker. I find things go best when I maintain a steady even teaching tempo minus lots of excitability. The SSW or understanding family can assist.

* Try to ignore more of the unacceptable behaviors, really praise the acceptable ones. Have patience. Do not be afraid to alter your program for this child; he/she really needs it. Be willing to try some different strategies (of your own or suggested by sp. ed. teacher) and be unorthodox. Try to be their friend and show genuine care for their lives. You may be the only teacher or adult who ever has!! Be very honest, but in a non-threatening manner. The child may not know why no one in class likes them, but if you and the child sit together, discuss it honestly and then set up some plan to help the child, it may just work.
* Be patient and find ways to praise the child. Shorten assignments so they can be successful.
* Ask for LD guidance and modify where possible when giving directions, etc.
* Keep a sense of humor, try to understand via seminars and classes. Try things other than standard classroom settings.
* Create a setting that allows student to self monitor but not distract from others.
* Structure the student's class and try to be very low key with them.
* Consult with counselor, special education coordinator or director, teacher, parent and student. Work together and modify expectation particularly with respect to time frame.
* Try all avenues 'til you find something that works for the student - each student is different and there is usually a way that you can help them.
* Be patient. The child is not purposely doing behaviors to annoy teacher. Think of the child as energetic - more positive.
* Maintain a sense of humor!
* Be flexible, allow some space for movement, continue to hold appropriate expectations, focus on the most basic issues.
* Always build on the student's strengths. Work with the parents and physician to get the needed help.
* Remember that the student(s) can't help it. Be understanding and patient. Keep classroom organized and circulate around the room.
* Use of study carrels and highly structured settings.
* Keep calm - realize the child is not behaving this way on purpose; make accommodations that you can live with; be sure to get a medical evaluation.
* Take classes, talk with other teachers, work with parents.
* Be consistent, care about the individual's feelings, and make sure they know the rules.

* All that you do to help the ADD student will also help the other children - as the student gets older involve them in the planning/strategies necessary for success. We must build self-esteem and develop a curriculum that will develop intrinsic and social motivation.
* Keep constant communication with parents and monitor for any changes that may occur due to medication becoming ineffective. Whenever I observe drastic behavior changes, I always suspect something is happening with the medication - usually correct.
* Try to attend classes/workshops, read journal articles and give specific interventions that I find have worked when asked.
* Be calm, understanding, patient, firm (yet flexible), consistent and structured.
* Structure tasks into small amounts with specific outcomes. Use color and organizational cues when needed.
* Be structured. Be very clear with directions. Offer opportunities for movement. Let the ADD child be the "helper."
* Be consistent; weekly assignment sheets are helpful check for understanding frequently; allow extra time for tests divided into sections and set timer.
* Cooperative grouping with students who are organized, patient and able to work with others.
* Be consistent. Be fair. Do not take the behavior personally. Build trust.
* Listen attentively to your students. Praise student's learning performance and give reason for praise.
* Remove as many distractors as possible. Help student become organized.
* Be willing to adjust curriculum to the needs of a child rather than have a child adjust to curriculum - be fair - not same.
* Patience - Patience - Patience. Consistent consequences.
* Break things down into very small segments and use immediate rewards for appropriate responses to those small segments. It may be work or just sitting at his desk for 3 minutes. A visible timer on the desk also helps to remind the child and teacher of the instant reward. Always give very clear and brief directions.
* Structure, minimum of distractions, reward system.
* Remaining consistent; structure; adhering to schedule.
* Establish eye contact before instructing - I talk; they talk! Repeat after me ..., etc.
* If one strategy isn't working, don't be afraid to be flexible and try a different approach.
* Give them praise when appropriate. Have them help another student practice a skill. Give visual clues on papers or the board for the directions.

* Structured setting, consistent routine, assignment sheet, positive reinforcements & make sure you have the student's attention before you begin instructions.
* All eyes on me!" "All eyes on the board!" "1, 2, 3, Look at me!" Have student(s) focus on a particular thing or person. Follow up with a statement such as "I see Scott and Melissa are ready."
* Everybody read this together - Get ready (or Begin)" Give a signal word(s) to let them know to start and keep the whole group in unison.
* Touch (point to) the first word of the paragraph (or directions or the picture or the word 'This', etc.). You can quickly scan the class or have a peer/partner check to see that the student(s) are on task.
* Touch the hand, shoulder or arm as you circulate the room while teaching.
* Lower your voice volume to capture attention.
* Stand silent - you could even look at the clock, then when you have their attention - go on with the lesson.
* Set a purpose ahead of time to have the student(s) cued in as to what to attend to - for instance "Paul after I read about volcanoes, I want you to tell me how hot they get."
* Seating - have student(s) easily accessible to physically reach and check to see if on task.
* Highlight directions with markers or different color chalk at the board.
* They must understand that the impulsivity, hyperactivity, etc. is beyond the control of the student. It's not something they choose to do.
* Seek support from peers - social worker, other teachers, parents.
* Try everything - the key is to be organized and eliminate unnecessary distractions.
* Let the student do a section of a worksheet or homework at a time. A whole sheet may be overwhelming for a student. Letting the student move around throughout the day after work is done (a section at a time) is also helpful.
* Work closely with family and school service teams. Urge medical intervention.

Appendix J

Other Comments Regarding ADD/ADHD

* I feel the student benefits best by nonverbal feedback in a group. Verbal feedback is important at the end of the class to reinforce good behavior or suggest remedies for inappropriate behavior.
* Most students diagnosed are ADHD. Doctors seem to be much more hesitant to diagnose the problem if there is no hyperactivity.
* Students w/ ADD can be frustrating to teach, but they are also the most rewarding when changes are noticed.
* Developing a closeness with students - letting them know I care about all aspects of their lives. They respond as they know I expect them to.
* We may work with those students a few hours a day. Parents have these youngsters a lifetime! (A glass of wine handy after a bad day.)
* Include LD/BD/EMH kids with regular kids as much as possible. I used to teach primary aged children 1-3. They have different issues than jr. high.
* Teachers need inservice on how to deal with ADD/ADHD in the classroom.
* I also read tests to or monitor test-taking to keep them "on" - to find out what they know - not how well they can take a test!
* Structure - Understanding.
* Large groups are difficult for these students.
* Have a working relationship with parents. Make sure you have the same expectations. There is an increase of identified children in reg. ed. classrooms - so keep a positive rapport with fellow teachers for the collegiality and peer work to aid students. Get parents involved in local C.H.A.D. meetings - go as a teacher to learn more about ADD.
* Don't bypass these children and call them dumb or daydreamers. They deserve the best education and a teacher who is willing to go the extra mile.
* One of the most frustrating group of kids to work with. Success must be measured in very small steps. Progress is very inconsistent.
* Medical intervention often works.
* Two of my students have been diagnosed as having ADHD/ADD by Dr.___ . One family gives medication regularly. The other family does not monitor the medication aspect like they should.
* I am an advocate of medication, because I have seen it work well in students. If it doesn't help significantly, I do not favor it.

* I have compiled a thick folder of ADD info from CHADD, workshops, magazines and newspapers to be shared with parents and teachers.
* I have had several students diagnosed as ADD or ADHD and find many varied behaviors between each student. Also, what works and doesn't work varies from situation to situation.
* True ADD kids respond positively to drug medication - many "ADD" students are receiving medication with no improvement to their academic performance. Doctors & parents need to monitor medication with input from teachers and school nurses. I am the parent of an ADD student - age 14.
* Set up weekly meeting with kid to review progress. Work with entire class to solve problem. Peer Involvement.
* Do what you say - consistently.
* Teacher can laminate and place on child's desk a sheet that shows such things as "stay in my seat," "sit quietly," "do nice work," "walk nicely in line," "raise hand to talk," "keep hands to myself," "be nice to my friends" and then just point to behavior wanted - non-verbal. Put stickers on, etc., etc.
* The use of medication greatly enhances the student's ability to stay on task.
* Let the child stand behind you to dictate - that way he/she gets the work done and you don't go crazy watching his "movement routine"!!
* Most of the ADHD children I have worked with showed great improvement in on-task behaviors after being placed on medication. This has allowed greater amounts of time for inclusion in regular division programs.
* It's been my experience that many regular ed. teachers would rather get disabled students out of their class rather than spend extra time helping them.
* Hang in there - gratification does not come easily or quickly.
* Most regular classroom teachers are very receptive to trying whatever works. The tricky part is what works for one student might not work for another. Consistency, perseverance, and a sense of humor are necessary components in an ADD/ADHD intervention program.
* These children behave very inconsistently and tend to be judged by the nature of their "highs" (a level of good behavior and performance that can't be met daily) and "lows" (tagged as not capable of better). There is no cure - Think Progress and Change. Use baseline behavior as measure to show improvement.
* Some students cannot handle oral praise and need to be praised privately.
* Ritalin is helpful to some students.

* Ritalin really does wonders with certain children. My students are old enough [5th & 6th grade] to notice the difference and effect medicine has and tell me things like "Everything makes sense!" "The room is quieter!" "I can work now and finish!"
* Be patient and consistent.
* I refer suspected ADD/ADHD students to our district's psychiatric consultant (from the Chicago Medical School) for diagnosis. This is a no-charge service for our parents. Many of these children do go on a medication and subsequently need only slight modifications.